Summer 8-11-2021

Testing a New Workflow to Integrate the Voice-of-the-Customer in Readmission Analysis for Skilled Nursing Facility Readmissions from Home

Stephanie Edurese Bilbao
University of San Francisco, SBilbao@usfca.edu

Testing a New Workflow to Integrate the Voice-of-the-Customer in Readmission Analysis for Skilled Nursing Facility Readmissions from Home

Stephanie Bilbao

University of San Francisco

NURS 670: Internship

Professor Liesel Buchner, MSN, RN, CNL

Professor David Ainsworth, MSN, RN, CNL

Professor Tara O'Connor, MSN, RN, CNL

July 25, 2021

Table of Contents

Section I: Title and Abstract

Title 1

Abstract 4

Section II: Introduction 5

Problem Description 6

Available Knowledge 7

PICOT Question 7

Literature Review 7

Rationale 8

Specific Project Aim 9

Section III: Methods

Context 10

Intervention 11

Study of the Intervention 12

Measures 13

Ethical Considerations 13

Section IV: Results 14

Section V: Discussion 15

Conclusion 17

Section VI: References 18

Section VII: Appendices

Appendix A. Evaluation Table 21

Appendix B. Donabedian's Quality Framework 24

Appendix C. Supporting Microsystem Profile..... 25

Appendix D. SWOT Analysis 27

Appendix E. Cost-Benefit Analysis / Return on Investment 28

Appendix F. Microsoft Forms Template 29

Appendix G. Project Charter..... 33

Appendix H. Statement of Non-Research Determination..... 40

Appendix I. Run Chart 43

Appendix J. Process Maps 44

Appendix K. Learnings, Issues, and Next Steps 45

Appendix L. Microsystem Team Roles and Functions 46

Section I: Abstract

There are multiple layers of oversight across the healthcare delivery system. Measuring acute hospital readmissions has been identified as an important outcome measure of quality care. Our patients are one of the major stakeholders in the healthcare system. One role of a clinical nurse leader is to integrate evidence-based leadership practices that identify and assess outcomes, mitigate risk, enhance health promotion, deliver highly effective patient care, and ensure transparent relationships with stakeholders. Rationales for examining and re-designing the readmission analysis workflow based on the customer's experience are discussed in this paper. The global aim of the project is to reduce skilled nursing facility (SNF) readmissions from home from 13% in 2020 to 10% in 2021. The specific aim is to increase utilization of the Voice-of-the-Customer template in readmission analysis for all SNF readmissions from home from 0% to 90% by July 15, 2021.

A telephone or face-to-face contact is initiated by a nurse case manager utilizing a script designed for this study. A Microsoft Forms template was used to document the survey details of the Voice-of-the-Customer as part of the readmission analysis. There were a total of 29 readmissions from home for the timeframe April 5, 2021, to July 15, 2021. Twenty-two met the inclusion criteria for the process improvement project. The team completed post-readmission contact and documentation on all 22 readmissions (100%), thereby meeting the outcomes measure goal. The process measure target was also met, as all but one, or 95%, of the patients/ caregivers participated.

Key opportunities identified for preventing hospital readmissions include improving patient and caregiver education with timely follow-up post SNF discharge and formalizing and routinely sharing best practices with SNF partners.

Section II: Introduction

The healthcare delivery system is faced with increased expectations regarding quality and safety. Stakeholders are increasingly looking for more efficient ways to deliver care. Within the healthcare delivery system, patients, payers, and the public have increased expectations concerning outcomes, safety, systems efficiency, patient satisfaction, and costs. According to Likosky (2014), it is essential to leverage microsystems to meet stakeholders' expectations. Cote et al. (2020) conducted a study to evaluate the impact of implementing clinical microsystems in the healthcare setting. The results of the study reflected:

> The implementation of clinical microsystems helped to develop the patient-centered approach, promote interdisciplinarity and quality improvement skills, increase the fluidity of the clinical acts performed, and increase patient safety. It contributed to increasing patients' and clinicians' satisfaction, as well as reducing hospital length of stay and reducing hospital-acquired infections (Cote et al., 2020, p. 388).

Microsystems are essential building blocks of the health system. Microsystems have clinical and business aims, linked processes, and a shared information environment, and they produce performance outcomes. Hospitals and healthcare organizations are made up of many microsystems. A microsystem cannot function independently from other microsystems or its macrosystem. Leaders at the macro level set clear expectations from each microsystem aligned to the organization's mission, vision, and strategies (Johnson & Sollecito, 2020).

Reducing avoidable hospital readmissions of skilled nursing facility (SNF) residents is a significant concern for healthcare providers and payers. The writer's microsystems' metrics reflect that meeting the goals for SNF readmissions is an opportunity. According to Khodyakov et al. (2019), patients and caregivers are increasingly recognized as key stakeholders in

developing clinical practice guidelines. Based on the review of the microsystem, it is apparent that the team has an opportunity to involve our patients, their families, and caregivers in our readmission work. The team collaborates with providers across the continuum of care, but has not included one major stakeholder—our patients. The successful implementation of this project is in line with the organization's strategies to provide exceptional care experiences, improve delivery of care, and reduce readmissions.

Problem Description

The organization's Northern California regional goal for SNF readmissions is 17% and observed/expected (O/E) of 0.72. From December 2019 to October 2020, the SNF department's performance was at 17% and 0.81 for a healthcare system in Fremont and 19% and 0.84 for a healthcare system in San Leandro.

Readmission reduction is a focused goal and quality metric for the organization and the department in 2021. The data reflect that 13% of SNF patients were readmitted after being discharged home from the SNF. The clinical nurse leaders's role integrates evidence-based leadership practices that identify and assess outcomes, mitigate risk, enhance health promotion, deliver highly effective patient care, and ensure transparent relationships with stakeholders. Our patients are one of the major stakeholders in the healthcare system. One strategy to improve healthcare delivery is by engaging patients and their caregivers in planning, delivering, and evaluating healthcare services. An opportunity identified in the microsystem assessment is the lack of patient/caregiver input, particularly readmission analysis and interventions. The team collaborates with providers across care venues; yet, we fail to incorporate the patient's voice and input. As an evidence-informed, quality improvement project, the team is looking to include the

patient's and the caregiver's voices in the readmission review and analysis. This significant metric is currently not being captured in the readmissions analysis workflow.

Available Knowledge

PICOT Question

The PICOT question used for the literature search and synthesis of evidence for this project asks: (P) In SNF patients, (I) will the implementation and documentation of a post-readmission survey, (C) compared to standard practice, assist in (O) reducing readmissions from home?

Literature Review

Systematic literature searches were conducted in PubMed and CINAHL. Keywords used were *readmissions, rehospitalizations, patient perceptions*, and *stakeholders in healthcare*. Search criteria were narrowed to studies dated within the last 5 years. One exception was a 2014 article chosen due to its significance. Eight studies were chosen based on relevance to the quality improvement project. The Johns Hopkins Nursing Evidence-Based Practice Research Evidence Appraisal tool was used to rate the studies.

In a modified-Delphi approach study, Khodyakov et al. (2019) reflected the importance of involving patients and caregivers in developing clinical practice guidelines. Six studies of various research designs demonstrated patients' perspectives on rehospitalization. In a Level III-A prospective cohort study, Carter et al. (2019) revealed that strengthening nonmedical support systems and general social policy may be required to reduce preventable readmissions. The study findings of Considine et al. (2020) highlighted the complexities of the discharge process and the importance of effective communication, shared decision-making, and caregiver engagement in optimizing hospital discharge and reducing early unplanned hospital readmissions. The results of

the qualitative descriptive design study by Gehring et al. (2019) underscored the importance of assessing patients' perceptions and expectations, the need to actively engage patients in their healthcare, and the importance of providing adequate support during the transition to home. Jeffs et al. (2014) revealed two main themes: readmissions as preventable occurrences and readmissions as inevitable. The study provided insights from multiple perspectives associated with readmissions and their preventability (Jeffs et al., 2014). The latter three studies were all evaluated as Level III-B, per the Johns Hopkins Nursing Evidence-Based Practice Research Evidence Appraisal tool.

In a narrative literature review, Santana et al. (2018) used the Donabedian health quality improvement model to classify patient-centered care domains. The framework provides a roadmap to guide the implementation of the patient-centered care model (Santana et al., 2018). Jacobsen et al. (2017) interviewed readmitted patients to gather information relevant to reducing readmissions. The findings from this study have potential implications for how SNF readmission data should be interpreted and how interventions to reduce readmissions should be designed in future studies (Jacobsen et al., 2017). Stein et al. (2016) also conducted patient interviews, which provided valuable insight into the patient's perspectives on readmissions. Both studies were rated III-A using the Johns Hopkins Nursing Evidence-Based Practice Research Evidence Appraisal tool. See Appendix A for the evaluation table of evidence-based research.

Rationale

Healthcare systems and organizations seek to improve quality and performance by implementing the patient-centered care model. At the heart of this writer's organization's nursing professional practice model are the patient and family. According to Kaiser Permanente (n.d.) nursing strategy professional practice model, "The nurse-patient/family relationship is the

cornerstone of nursing practice and leverages the powerful role human relationships play in creating caring and healing environments" (para. 1). In addition, Mead and Bower (2000) advocated that patient-centered care should consider the patient as "an experiencing individual beyond being just an object of disease" (p. 1089), which means that healthcare providers must have an understanding of the patient's context and perspective.

The Donabedian model for healthcare improvement can be used to assess the quality of care using structure, process, and outcome components of patient-centered care (Santana et al., 2018; see Appendix B). The framework emphasizes the structural domain or setting, the healthcare delivery system or the organization providing the services. Interactions between the patients and their support systems and healthcare providers comprise the process domain. Listening, sharing information, and discussing care plans cultivates communication and encourages patients to be more engaged participants in their care. The third domain, which is health outcomes, includes timely and affordable access to care. Patient-reported outcomes and experiences are also essential aspects of this domain (Santana et al., 2018).

The Donabedian model for healthcare improvement provides the framework to guide the implementation of this project, particularly on the aspect of patient and support system involvement and participation in their own care. It can also be applied on the inclusion of service evaluation and provides a better insight into patients' experiences with their care. All translates to focus on patient care and safety as a quality indicator of healthcare delivery.

Specific Project Aim

This project aims to increase utilization of the voice-of-the-customer (VOC) workflow in readmission analysis for all SNF readmissions from home from 0% to 90% by July 15, 2021.

Section III: Methods

Context

A microsystem assessment using the Supporting Microsystems Profile tool was conducted to evaluate readiness to embrace and implement the project activities (see Appendix C). The microsystem examined in this study is the SNF department of a healthcare system in Northern California, more specifically in the service area in Alameda County. The average daily census of patients in the SNFs is 300. The department's leadership includes a continuum administrator, service director, department manager, and physician chief. The organization's SNF department is comprised of well-experienced nurse case managers whose primary role is to coordinate and facilitate care and services for patients in the SNFs. A quality continuum improvement advisor works closely with the SNF manager in readmission reduction projects.

Implementating the workflow to integrate the the VOC in readmissions analysis is one the department's primary initiaves in its readmission reduction efforts. A team comprised of physician and nurse champions, as well as an information technology consultant, was identified. The sponsors are the physician chief of continuum of care and the continuing care service director. Education and training for the nurse case managers in experiential interviewing and using the Microsoft (MS) Forms template for readmission analysis was conducted. For the successful implementation of the VOC workflow, consistent participation from the nurse case manager is vital. A potential barrier identified is a lack of consistency in standardized documentation by nurse case managers, as this task will be added to their existing workload.

A strengths, weaknesses, opportunities, and threats (SWOT) analysis was conducted to identify factors that would help facilitate the successful implementation of the project, as well as potential problems that need to be recognized and addressed (see Appendix D).

Aside from the the financial penalty for readmissions by the Centers for Medicare and Medicaid Services (CMS), the cost of avoidable readmissions also creates a significant financial burden to the organization and healthcare delivery system. According to the service area finance manager, the daily cost of a readmission in a med-telemetry unit is $2,166, and the average length of stay (LOS) is 2.4 days. In an ICU, the daily rate is $3,640, and the LOS is 3.2 days. The total cost avoidance of one prevented readmission is $31,188 to $69,888. The training costs for the nurse case managers on experiential interviewing and documentation using the MS Forms platform amounted to $664. The amount spent on the hourly nurse wages for the weekly 1-hour debriefs is $1,328. The total cost of the improvement project is $1,992. The return on investment (ROI) is calculated at $29,196 to $67,896. See Appendix E for the Cost-Benefit Analysis/ROI table.

Intervention

The evidence-based quality project's specific intervention is to test the use of a new workflow to integrate the VOC in readmission analysis for SNF readmissions from home. The included population are skilled SNF patients rehospitalized from home who were discharged from the five primary contracted SNFs in the service area. The project excluded patients from non-primary contracted SNFs, those who left against medical advice, and those with discharge locations other than SNFs on the indexed hospitalization. Nurse case managers, physicians, administrators, and patients were involved in the development and validation of the workflow. The workflow was revised based on their feedback and recommendations.

The specific interventions included obtaining a daily report from the business strategy and finance department to identify readmitted patients from the previous day. This finance report shows inpatient and observation patients admitted to the hospital on the date listed who were

either discharged or admitted from the facility selected within 30 days before the current admission. In addition, the team completed a retrospective review of readmissions from home in 2019 and 2020 to establish a baseline. Team members used a MS Forms template to document the details of the VOC as part of the readmission analysis (see Appendix F). Using the new template in MS Teams, the nurse case managers conduct a post-discharge call. The number of documented calls completed is then compared against the business strategy and finance report to determine compliance. Other pertinent data will be generated from the MS Forms platform.

Study of the Intervention

There is an existing biweekly readmission committee meeting within the department, and the planning, implementation, monitoring, and evaluation of the project is discussed in this venue. Barriers and challenges are also addressed in these meetings with the physician and nurse champions. A monthly service areawide meeting also takes place, wherein the current state of the project is discussed with a larger group.

During the first plan-do-study-act (PDSA) cycle, a standardized workflow and template were initiated and reviewed with the different stakeholders: physicians, nurses, nursing home administrators, directors of nurses, and patients. Adjustments to the workflow were made based on the feedback received. A Health Connect smart phrase was built based on an existing smart phrase used by the inpatient team. However, after further validation, the group decided to abandon this, as there was limited capacity to generate reports from Health Connect. A new MS Forms template was created that better fit the demands of the project.

The MS Forms template is utilized for the readmission analysis within 7 business days of a SNF readmission from home. The MS Forms allows the team to track data and evaluate ongoing small tests of change, as this is an ongoing project. The PDSA cycles for this project

will focus on the completion of the template and will identify themes and opportunities. A report will be generated biweekly and presented to the department readmission committee. A monthly report will likewise be completed and discussed in the service areawide cross-continuum readmission committee meeting.

Measures

Measures for the VOC integration to readmission analysis project are focused on the documentation of post-readmission contacts. The outcome measure for this project is the number of documented post-readmission contacts using the designed MS Forms template. The process measure is the percentage of patients/designated caregivers who participated and answered the questions. The number of member service concerns related to care coordination of home discharge is the balancing measure. The Project Charter contains more information on the measures, data sources, and targets for this project (see Appendix G).

Ethical Considerations

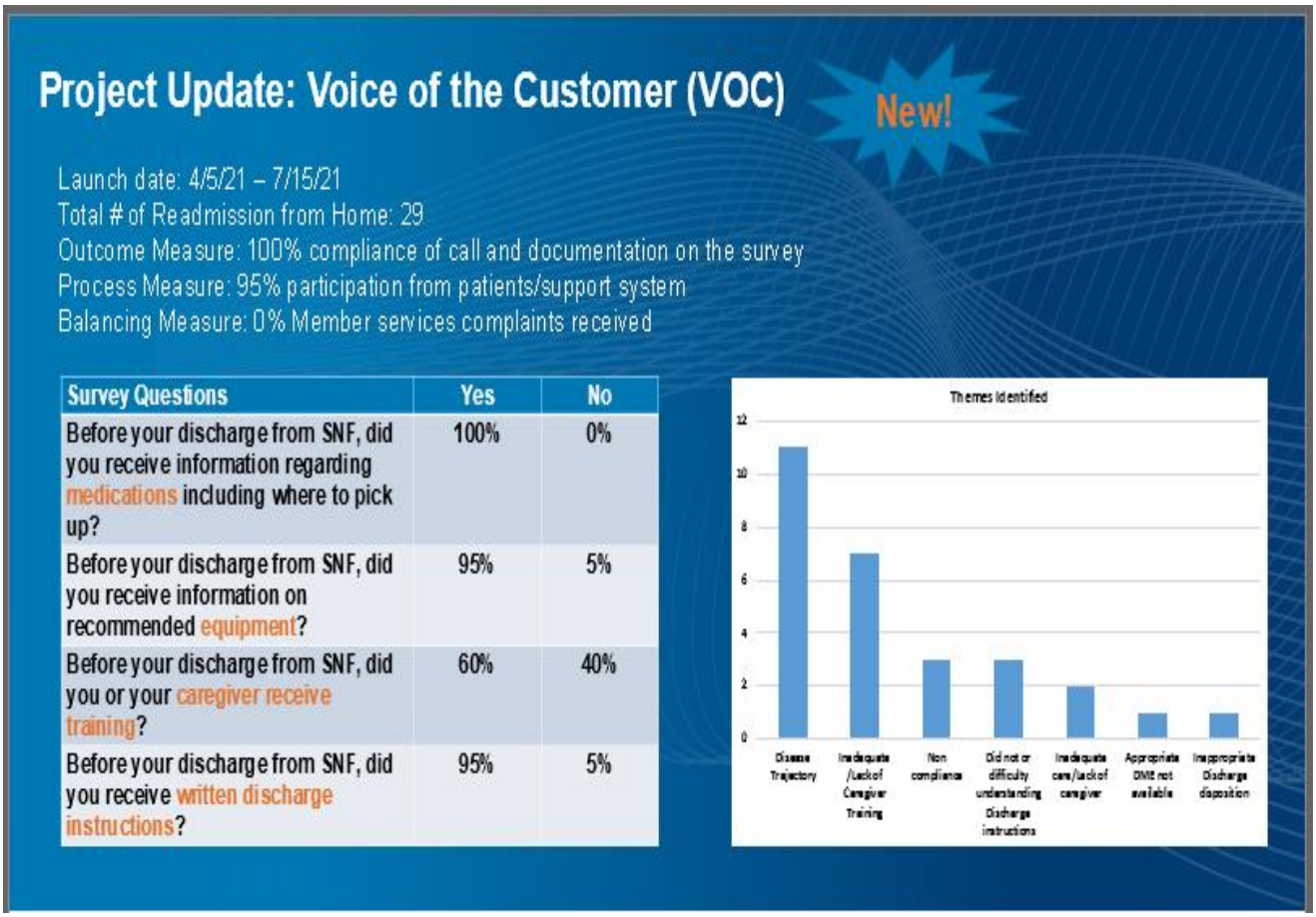
The University of San Francisco faculty reviewed this project and determined that it qualifies as an evidence-based performance improvement project versus a research paper. The faculty approved the statement of determination as a non-research project (see Appendix H). Institutional Review Board approval was not required. Consent is obtained from the patients and/or support systems before proceeding with questions. Participation is voluntary. Protection of the participant's privacy and confidentiality is ensured. The focus of this performance improvement project is on readmitted patients from home. Due to staffing availability and time constraints, readmissions from other venues are excluded.

Section IV: Results

There were a total of 29 readmissions from home for the timeframe April 5 to July 15, 2021. Twenty-two met the inclusion criteria for the process improvement project. Seven were excluded. The team completed post-readmission contact and documentation on all 22 readmissions or 100%, thereby, meeting the outcomes measure goal. The process measure target was also met, as all but one, or 95%, of the patients/caregivers participated in the call. Consistent exceptional results is expected to be maintained, as the project has been hard-wired in the current readmission analysis workflow. See Figure 1 for the VOC project data.

Figure 1

VOC Integration to Readmissions Analysis Data



Section V: Discussion

Integrating the VOC in the readmission analysis of SNF readmissions from home was successfully implemented. Patients and caregivers are key stakeholders in the healthcare delivery system. Providing patient-centered care involves gaining insight on patient perceptions and expectations and engaging them in their own healthcare. The accomplishment of this project is in line with the organization's aim to provide exceptional care experiences, improve delivery of care, and reduce preventable readmissions. Leadership support, as well as nurse case manager engagement, significantly contributed to the successful implementation of this project.

The team was surprised to learn that patients and caregivers were eager to participate and share both good feedback and opportunities. Only one out of 22 patients who met the criteria declined to participate. Non-English speaking patients were not excluded in this project. Using the Language Line interpreter services was helpful; although, the team felt that the responses of patients requiring interpreters provided less detail.

An important learning during was to review the chart first before making the contact. A nurse case manager contacted a patient's wife only to find out that the patient expired two days prior. Timing the contact is also vital. In July 2021, staffing challenges were encountered due to maternity leave and pre-approved paid time offs (PTO). A few contacts were made seven days after the readmission, and it was noted that patients and caregivers verbalized that they could not recall specific details related to the SNF discharge.

On discharge, a nurse presents and explains written instructions to the patient or family. Discharge instructions provide critical information for patients to manage their own care. A theme that stood out based on feedback from patients and caregivers was the lack of or inadequate discharge teaching prior to transitioning from the SNF, which may result in poor

compliance to treatment and a potential avoidable return to the hospital. Upon discussion with the SNF partners, the SNF leadership concurred that there is opportunity to improve on providing a more comprehensive and detailed discharge teaching. The SNF manager and quality nurse consultant will be taking next steps to standardize the discharge process by observing and training SNF nurses on providing discharge teachings and in creating a script or job aide to guide the SNF nurse when providing care instructions. In the last quarter of 2021, the key nursing staff of the primary contracted SNFs will be invited to an in-person or teams forum where evidence-based clinical models and best practices can be shared, including using role-play as a teaching method.

Another feedback related to this was that the format of the medication list on the physician SNF discharge instructions was not as clear and easy to follow as that of the hospital discharge paperwork. There is ongoing work with the regional physician model of care group in updating the format of the SNF discharge instructions, as Health Connect currently cannot generate the medication list in the similar format.

Since April 2021, the team presented a report on the progress of this initiative on the monthly service areawide readmission committee meeting. Learnings on the inadequate discharge teachings can be generalized to other venues of care, including the inpatient setting and continuum. In quarter three of 2021, the service area will have Master in Case Management students who will intern in the readmission program. The program has adopted the MS Forms template that was used in this project to document outcomes of their patient outreach.

The physician group shared the same interest and engagement in implementation of the VOC project as the SNF team did. The department chief will be presenting highlights and learnings to the service area physician-in-chiefs.

Section VI. Conclusion

The accomplishment of the integration of the VOC in readmission analysis project is in line with the organization's aim to provide exceptional care experiences, improve delivery of care, and reduce preventable readmissions. Patient-centered care models are implemented by healthcare systems to improve quality and performance. The study of Mead and Bower (2000) reflected that patient-centered care should consider the patient as "an experiencing individual beyond being just an object of disease" (p. 1089), which means that healthcare providers must have an understanding of the patient's context and perspective. This aspect was addressed by the VOC project.

Implementing the integration of the VOC on readmission analysis has the continued support of both department leadership and physicians. Furthermore, the nurse case managers in the department recognize that seeking feedback from patients and their support systems is essential. Outside of the microsystem, the leadership of community SNFs are also on board in implementing changes based on constructive feedback received from patients. The SNFs' quality assurance and performance improvement programs aim to improve processes involved in the healthcare delivery and quality of life of nursing home residents.

In this quality improvement project, the Clinical Nurse Leader (CNL) integrated evidenced-based practices on patient-centered care which can significantly enhance delivery of effective care. As an advocate, the CNL ensures that patients and their support systems are well-informed and included in planning their care. The global aim of the project is to assist in the reduction of SNF readmissions from home. Key opportunities identified for preventing hospital readmissions include improving patient and caregiver education with timely follow-up post SNF discharge and formalizing and routinely sharing best practices with SNF partners.

Section VII: References

Carter, J., Ward, C., Thorndike, A., Donelan, K., & Wexler, D. J. (2019). Social factors and patient perceptions associated with preventable hospital readmissions. *Journal of Patient Experience*, *7*(1), 19–26. https://doi.org/10.1177/2374373518825143

Considine, J., Berry, D., Sprogis, S. K., Newnham, E., Fox, K., Darzins, P., Rawson, H., & Street, M. (2020). Understanding the patient experience of early unplanned hospital readmission following acute care discharge: A qualitative descriptive study. *BMJ Open, 10*(5), e034728. https://doi.org/10.1136/bmjopen-2019-034728

Cote, A., Beogo, I., Abasse, K. S., Laberge, M., Dogba, M. J., & Dallaire, C. (2020). The microsystems approach: Does it really work? A systematic review of organizational theories of health care practices. *Journal of the American Pharmacists Association, 60*(6), e388–e410. https://doi.org/10.1016/j.japh.2020.06.013

Gehring, M. B., Lerret, S., Johnson, J., Rieder, J., Nelson, D., Copeland, L., Titan, A., Hawn, M., Morris, M., Whittle, J., & Burns, E. (2019). Patient expectations for recovery after elective surgery: A common-sense model approach. *Journal of Behavioral Medicine*, *43*(2), 185–197. https://doi.org/10.1007/s10865-019-00097-2

Jacobsen, J., Schnelle, J. F., Saraf, A. A., Long, E. A., Vasilevskis, E. E., Kripalani, S., & Simmons, S. F. (2017). Preventability of hospital readmissions from skilled nursing facilities: A consumer perspective. *Gerontologist, 57*(6), 1123–1132. https://doi.org/10.1093/geront/gnw132

Jeffs, L., Dhalla, I., Cardosa, R., & Bell, C. (2014). The perspectives of patients, family members and healthcare professionals on readmission: Preventable or inevitable. *Journal of Interprofessional Care, 28*(6), 507–512. https://doi.org/10.3109/13561820.2014.923988

Johnson, J. K., & Sollecito, W. A. (2020). *McLaughlin and Kaluzny's continuous quality improvement in health care* (5th ed.). Jones & Bartlett Learning.

Kaiser Permanente. (n.d.). *Nursing strategy. Professional practice model*. https://kpnursing.org/nursingstrategy/practicemodel.html

Khodyakov, D., Grant, S., Denger, B., Kinnett, K., Martin, A., Peay, H., & Coulter, I. (2019). Practical considerations in using online modified-Delphi approaches to engage patients and other stakeholders in clinical practice guideline development. *The Patient – Patient-Centered Outcomes Research, 13*(1), 11–21. https://doi.org/10.1007/s40271-019-00389-4

Likosky, D. S. (2014). Clinical microsystems: A critical framework for crossing the quality chasm. *Journal of ExtraCorporeal Technology, 46*, 33–37. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4557508/pdf/ject-46-33.pdf

Mead, N., & Bower, P. (2000). Patient-centredness: A conceptual framework and review of the empirical literature. *Social Science & Medicine, 51*(7), 1087–1110. https://doi.org/10.1016/S0277-9536(00)00098-8

Santana, M. J., Manalili, K., Jolley, R. J., Zelinsky, S., Quan, H., & Lu, M. (2018). How to practice person-centred care: A conceptual framework. *Health Expectations, 21*(2), 429–440. https://doi.org/10.1111/hex.12640

Stein, J., Ossman, P., Viera, A., Moore, C., Brubaker, B., French, J., & Liles, E. A. (2016). Was this readmission preventable? Qualitative study of patient and provider perceptions of readmissions. *Southern Medical Journal, 109*(6), 383–389. https://doi.org/10.14423/smj.0000000000000465

Section VIII: Appendices

Appendix A. Evaluation Table

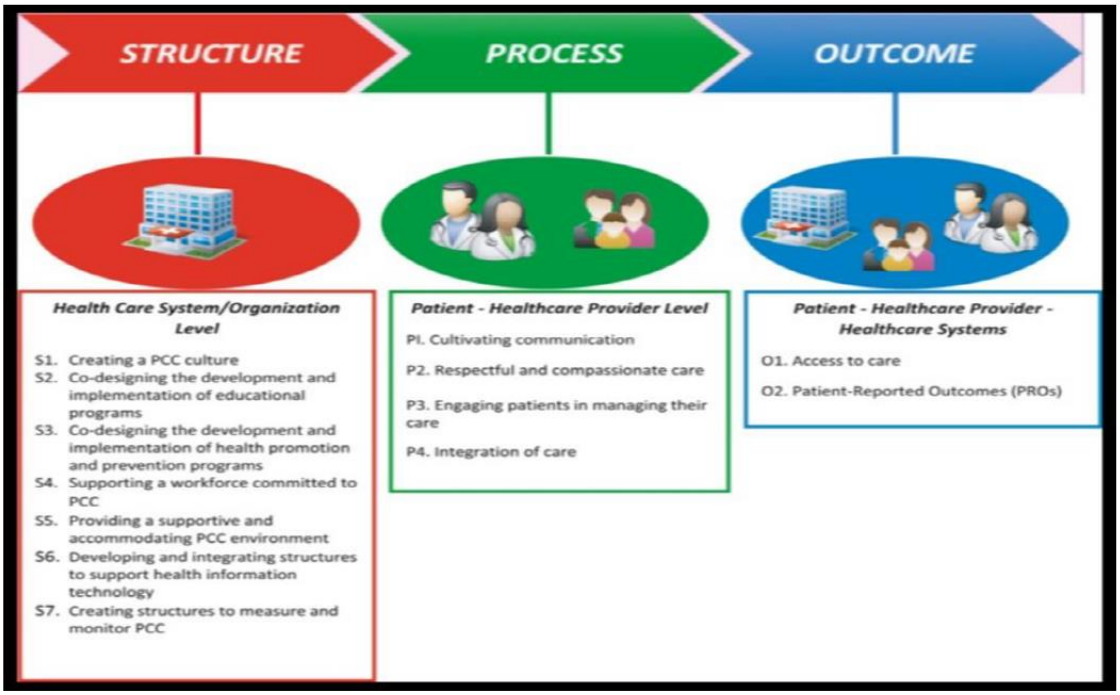
PICOT Question: In SNF patients, will the implementation and documentation of a post-readmission survey assist in reducing readmissions from home?

Study	Design	Sample	Outcome/Feasibility	Evidence Rating
Khodyakov, D., Grant, S., Denger, B., Kinnett, K., Martin, A., Peay, H., & Coulter, I. (2019). Practical considerations in using online modified-Delphi approaches to engage patients and other stakeholders in clinical practice guideline development. *Patient – Patient-Centered Outcomes Research*, *13*(1), 11–21. https://doi.org/10.1007/s40271-019-00389-4	Modified – Delphi approach	Study did not identify the number of participants. It did mention that they worked individuals with Duchenne muscular dystrophy (DMD) and their caregivers.	The importance of involving patients, caregivers, and/or their representatives in the process of developing CPGs has been recognized by guideline developers. Limitations identified are both developer and patient require internet access and a device, varied patient online experiences, and training in data collection is necessary. Useful for developing a tool to use in determining patient-centeredness of SNF discharge care guidelines.	V-A
Carter, J., Ward, C., Thorndike, A., Donelan, K., & Wexler, D. J. (2019). Social factors and patient perceptions associated with preventable hospital readmissions. *Journal of Patient Experience*, *7*(1), 19–26. https://doi.org/10.1177/2374373518825143	Prospective cohort study	202 respondents readmitted within 30 days of hospital discharge from two inpatient adult medicine units at hospital in Boston, MA between Jan. 2012 and Jan. 2016.	Strengthening nonmedical support systems and general social policy may be required to reduce preventable readmissions. Useful for developing a survey questionnaire to be used in patient experience interviews.	III-A

Study	Design	Sample	Outcome/Feasibility	Evidence Rating
Considine, J., Berry, D., Sprogis, S. K., Newnham, E., Fox, K., Darzins, P., Rawson, H., & Street, M. (2020). Understanding the patient experience of early unplanned hospital readmission following acute care discharge: A qualitative descriptive study. *BMJ Open*, *10*(5), e034728. https://doi.org/10.1136/bmjopen-2019-034728	Qualitative descriptive design	30 patients, patient-carer dyads, carer in three acute care hospitals from one health service in Australia.	The study findings highlight the complexities of the discharge process and the importance of effective communication, shared decision-making, and carer engagement in optimizing hospital discharge and reducing early unplanned hospital readmissions. Useful in identifying themes and future focus interventions.	III-B
Gehring, M. B., Lerret, S., Johnson, J., Rieder, J., Nelson, D., Copeland, L., Titan, A., Hawn, M., Morris, M., Whittle, J., & Burns, E. (2019). Patient expectations for recovery after elective surgery: A common-sense model approach. *Journal of Behavioral Medicine*, *43*(2), 185–197. https://doi.org/10.1007/s10865-019-00097-2	Qualitative descriptive design	Convenience sample of 14 patients at a Midwestern VA hospital.	The results underscore the importance of assessing patients' perceptions and expectations, the need to actively engage patients in their own healthcare, and the importance of providing adequate support during the transition to home. Useful for developing a survey questionnaire to be used in patient experience interviews, as well as a possible conceptual framework for quality improvement project.	III-B
Jeffs, L., Dhalla, I., Cardosa, R., & Bell, C. (2014). The perspectives of patients, family members and healthcare professionals on readmission: Preventable or inevitable. *Journal of Interprofessional Care*, *28*(6), 507–512. https://doi.org/10.3109/13561820.2014.923988	Exploratory case design	49 participants, including patients, family members, nurses, case managers, physicians, and discharge planners from a general medicine unit at a large academic hospital.	The outcome of the study revealed two main themes: readmissions as preventable occurrences and readmissions as inevitable. The study provided insights from multiple perspectives associated with readmissions and their preventability. Useful in identifying themes and future focus interventions.	III-B

Study	Design	Sample	Outcome/Feasibility	Evidence Rating
Santana, M. J., Manalili, K., Jolley, R. J., Zelinsky, S., Quan, H., & Lu, M. (2018). How to practice person-centred care: A conceptual framework. *Health Expectations, 21*(2), 429–440. https://doi.org/10.1111/hex.12640	Narrative review of literature	N/A	Using the Donabedian health quality improvement model to classify patient-centered care domains, the framework provides a roadmap to guide the implementation of the patient-centered care model. Useful in developing a conceptual framework for developing a quality improvement project.	V-A
Jacobsen, J., Schnelle, J. F., Saraf, A. A., Long, E. A., Vasilevskis, E. E., Kripalani, S., & Simmons, S. F. (2017). Preventability of hospital readmissions from skilled nursing facilities: A consumer perspective. *Gerontologist, 57*(6), 1123–1132. https://doi.org/10.1093/geront/gnw132	Structured interview	Data were collected from 156 participants with unplanned readmissions from 23 SNFs within 60 days of a previous hospital discharge.	Interviewing readmitted patients provides information relevant to reducing readmissions. The findings from this study have potential implications for how SNF readmission data should be interpreted and used on a regulatory level and how interventions to reduce readmissions should be designed in future studies. Useful in identifying themes and future focus interventions.	III-A
Stein, J., Ossman, P., Viera, A., Moore, C., Brubaker, B., French, J., & Liles, E. A. (2016). Was this readmission preventable? Qualitative study of patient and provider perceptions of readmissions. *Southern Medical Journal*, *109*(6), 383–389. https://doi.org/10.14423/smj.0000000000000465	Descriptive statistics and qualitative analysis	213 provider chart reviews were conducted and interviews with 23 readmitted patients.	The data provided valuable insight into the perspectives of patients and providers on readmissions. Useful in identifying themes and future focus interventions.	III-A

Appendix B. Donabedian's Quality Framework



Appendix C. Supporting Microsystem Profile

Supporting Microsystem Profile

A. *Purpose:* Why does your microsystem exist? **Department Vision: To facilitate and coordinate the best care experience for Kaiser members in the SNF Setting.**

1. *To support throughput from Medical Centers by facilitating and coordinating appropriate SNF Placement.*
2. *Care Coordination and Utilization Management of services and insurance benefits of Kaiser members in SNFs.*
3. *Quality and Safety management and monitoring including Readmission Reduction interventions.*
4. *To provide educational support to maintain / improve skills capacity of SNF staff.*
5. *To facilitate seamless transitions of SNF patients to next appropriate level of care.*
6. *To aid KP Physicians as they clinically manage care of patients.*

Name of Service: SNF Services	Site Contact: Stephanie Bilbao	Date: 9/18/2020
Service Manager: Stephanie Bilbao	Service Lead:	

B. Know Your Customers: Take a close look into your microsystem; create a "high-level" picture of the Customers that you serve. Who are they? What resources do they use/request? How do customers view the services they receive?

Est. Distribution of workload	**%**	**List Your Top 10 Work type requests – not in any particular order**		**Top requesting Customers**	**Customer Satisfaction Scores: FYI SNF Department is not included in HCAHPS Survey: Info below based on SNF Vendor and Physician Feedback, SNF patient satisfaction survey, People Pulse Survey**	**% Excellent**
Source- KP Members, family, caregivers	30	1.Utlization Management of KP pts in SNFs	6. Change of Condition reports to SNF Advice call center	KP Members, Family, Caregivers	Experience via phone	80
Source- KP SNF Physicians	20	2. SNF Placement and escalations	7.Workgroup/ project meetings	KP Physicians	Length of time to get complete work	80
Source- SNF Vendors (Leadership and interdisciplinary team)	20	3.Discharge Planning and Care Coordination	8. HR-related: staffing, operational and administrative tasks	Medical Centers/ Acute Care Hospitals	Accuracy of work	80
Source- Medical Centers / Acute Care Hospitals	15	4.Readmission Reviews and discussion	9.	SNF Vendors	Satisfaction with personal manner	90
Source- Department Leadership and Staff	10	5.Quality and Member Services Complaints	10.		Satisfaction with work product	80
Source: Other KP Outpatient Departments	5	Customers who are frequent users of your service and their reasons for interacting with your microsystem		Other services you interact with regularly as part of your normal work processes.	Work load distribution: Do these numbers change by season? (Y/N)	# / Y/N
Est. # of work requests in last month	6K				Work load in a day	300 / Y
					Work load in last week	1.5K / Y
					Work load in last month	6K / Y
Top Payors					Other	
Managed Care Plans						
Medicare		.				

Kaiser Commercial Insurance			
Private Pay Medi-Cal Long term Care insurance			

***Complete "Through the Eyes of Your Customer**

C. *Know Your Professionals:* Use the following template to create a comprehensive picture of your microsystem. Who does what and when? Is the right person doing the right activity? Are roles being optimized? Are all roles who contribute to the patient experience listed? What hours are you open for business? What is the morale of your staff?

Current Staff	FTEs	Role/Function		Days of Operation	Hours of Operation
Enter names below totals (Use separate sheet if needed) **Please see separate sheet for Roles and Functions**				Monday	8:30 | 1700
				Tuesday	8:30 | 1700
Microsystem Total	19.4			Wednesday	8:30 | 1700
				Thursday	8:30 | 1700
SNF Director	1.0			Friday	8:30 | 1700
SNF Manager	1.0			Saturday	As needed |
SNF Physicians	7.0			Sunday	As needed |
SNF Quality RN/ Educator	1.0		**Which activities are you involved in? Check all that apply.**		
Continuing Care Utilization Review Coord RN 3 - 1.0 FTE/each 1 - .0.8 FTE	3.8		Regularly attend / run clinical microsystem meetings.		
SNF Advice RN 3 – 0.6/ each	1.8		Receives escalations for extended lengths of stay / hard to place cases from medical centers needing SNF beds.		
Administrative Assistant	1.0		Reviews utilization/ Complex cases and provides recommendations based on evidence-based practices.		
Department Clerk	1.0		Collaborates with physicians and other providers across the continuum of care on readmission reviews and reduction interventions.		
Rehab Outcomes Coordinator	08				
High Mobility OT	1.0				

Work Type	Cycle Time	Comment

Do you use a Float Pool?	NO
Do you use On-Call?	YES
Do you use Per Diems?	NO

Staff Satisfaction Scores		%
How stressful is this microsystem?	% Very stressed	70%
Would you recommend it as a good place to work?	% Strongly Agree	90%

***Each staff member should complete the Personal Skills Assessment and "The Activity Survey"**

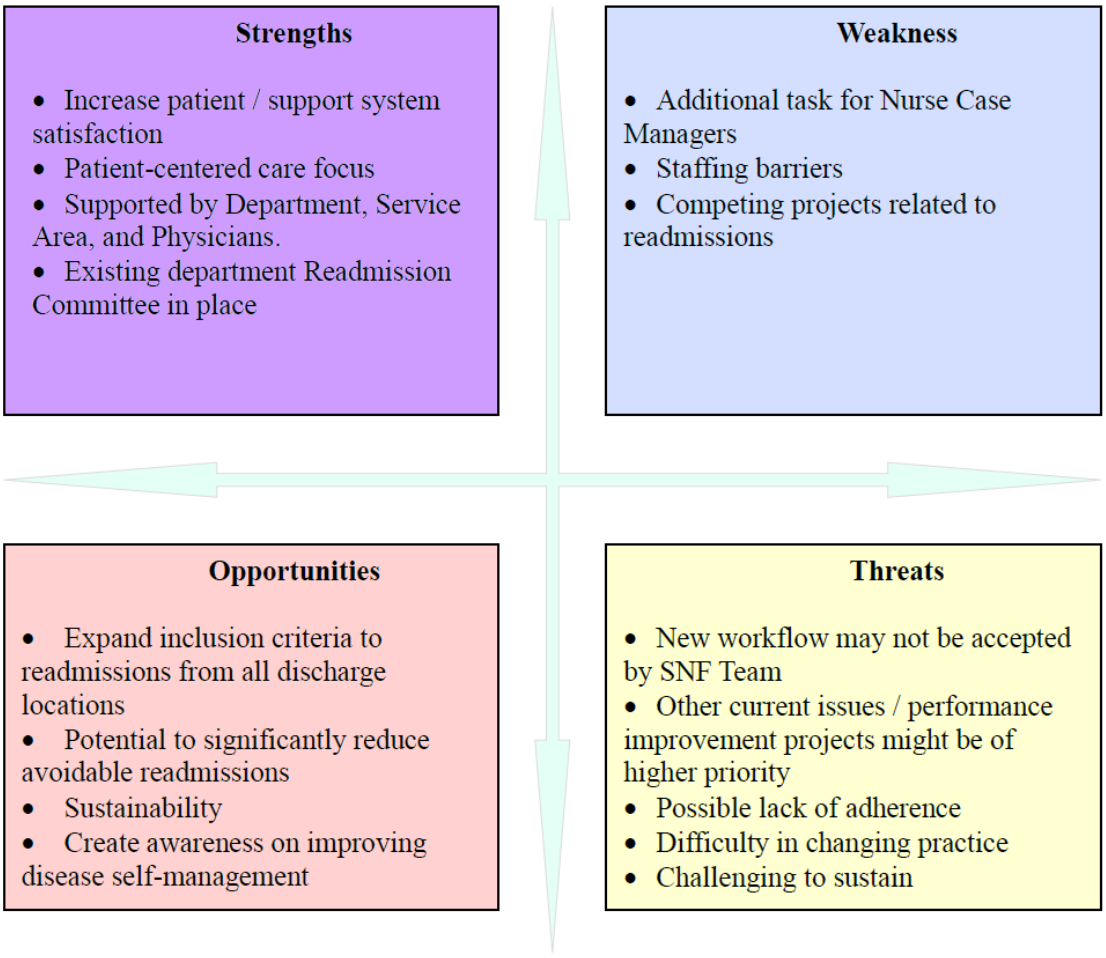
D. *Know Your Processes:* How do things get done in the microsystem? Who does what? What are the step-by-step processes? How long does it take to complete the work here, are the delays? What are the "between" microsystems hand-offs? Have you discussed a shared purpose with clinical microsystems and other supporting microsystems?

1. Track cycle time from work requested, work assigned, work completed, final product sent to customer.
2. **Complete the Core and Supporting Process Assessment Tool**

E. *Know Your Patterns:* What patterns are present but not acknowledged in your microsystem? What is the leadership and social pattern? How often does the microsystem meet to discuss processes? Are customers involved? What are your results and outcomes?

▪ Does every member of the microsystem meet regularly as a team? Yes	▪ Do the members of the microsystem regularly review and discuss errors, safety and reliability issues? Yes. Daily, Monthly, and as needed.	▪ What have you successfully changed? Implementation of standard workflows and processes – SNF IDT rounding, transitions, readmissions, goals of care reviews and documentation COVID testing and infection control training
		▪ What are you most proud of? Our Team of dedicated, hardworking, experienced providers who readily participate in performance improvement activities and open to embrace change
▪ How frequently? Daily (Mon to Fri) during huddle		▪ What is your financial picture? **Aug YTD budget = $4,876,835 + variance**
▪ What is the most significant pattern of variation? **Big opportunity to focus on the Voice of the Patient/ Caregiver, particularly on readmissions. We collaborate with providers across the continuity of care but have not included one major stakeholder – our PATIENTS!**		***Complete "Metrics that Matter"**

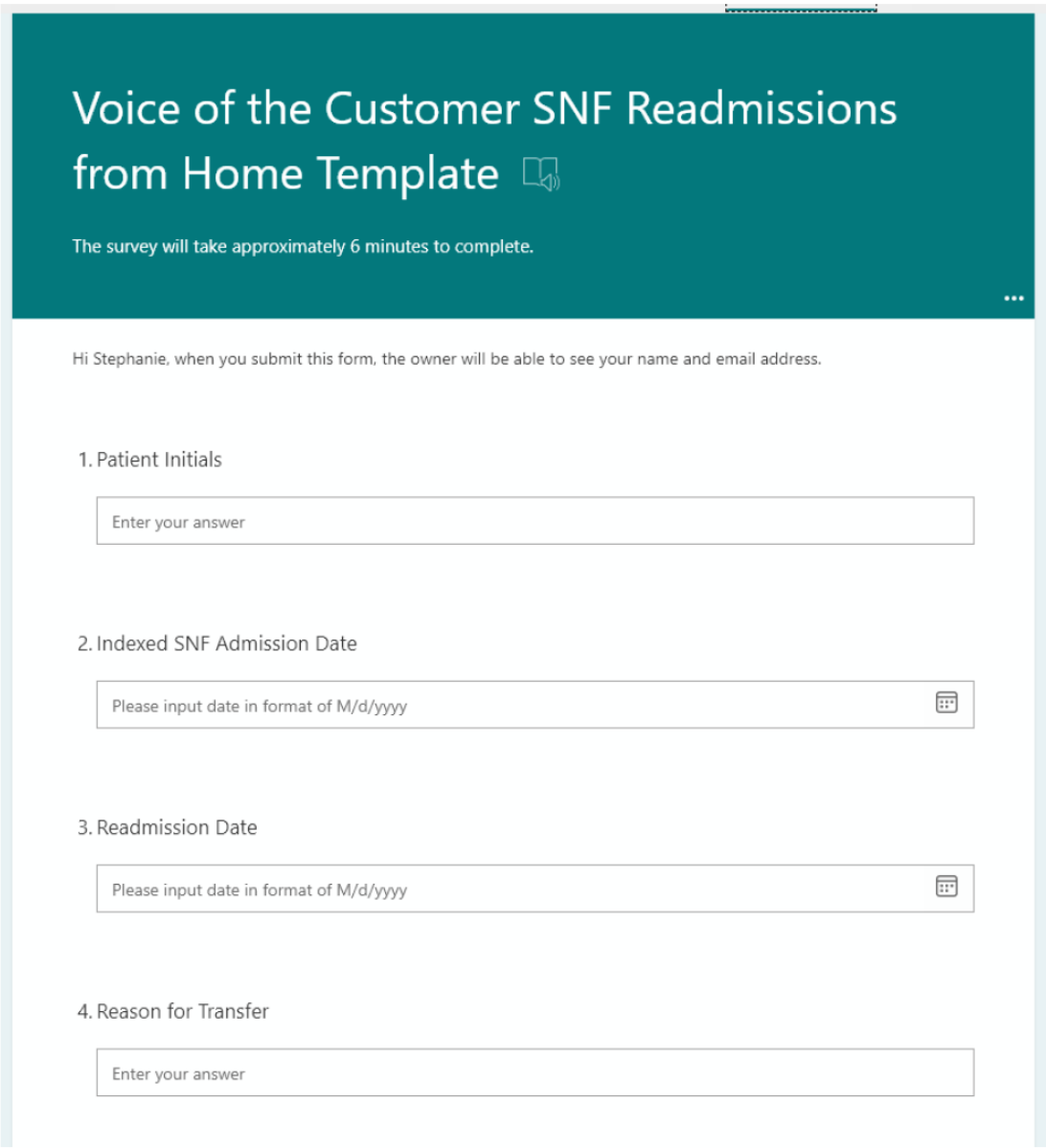
Appendix D. SWOT Analysis



Appendix E. Cost-Benefit Analysis / Return on Investment

Improvement Goal	Improvement Cost	Readmission Cost	Revenue Improvement through Cost Avoidance	ROI
To reduce SNF readmissions from home from 13% in 2020 to 10% in 2021	Cost of implementing the Voice-of-Customer (VOC) workflow is analysis of SNF readmissions from home	Med TeleDaily Rate=$2166 Ave LOS = 2.4 Cost = $5198/ pt/ readmission ICU Daily Rate = $3640 Ave LOS 3.2 Cost = $11648/ pt/ readmission	Avoid 1 SNF Readmit from home/month (July to Dec 2021)	$31,188 - $1992 =$29196 $69,888 - $1992 = $67,896
53 = # of SNF Readmissions from Home in 2020	2 hour training $83/hr x 2 hours x 4 RNs in the SNF Department = $664		Med Tele: $5198 x 6 patients =$31,188. ICU: $11648 x 6 patients =$69,888	Projected savings for 6 readmits in 6 months= $29,196 to $67,896 for 2021
5 -= Average# SNF Readmissions from Home / month (Jan to June 2021)	Weekly one hour debrief $83/hr x 4 RNS x 4 weeks =$1328			annualized savings for 2022= $62,376 to $139,776
	Total Improvement Cost= $1992		Total Cost Avoidance of one readmit/month = $5198 to $11648	

Appendix F. Microsoft Forms Template



5. Interview Source

- [ ] Patient
- [ ] Spouse
- [ ] Son/ Daughter
- [ ] Hired Caregiver (home, ALF, B and C)
- [ ] Other

6. Name of SNF

- ( ) Windsor Country Drive
- ( ) Windsor Gardens
- ( ) Hayward Health Care Center
- ( ) Baypoint Nursing and Rehab
- ( ) Windsor Park

7. Interviewer Name

Introduction after Validating Patient/Caregiver Identifier

My name is ***. I am a Nurse from Kaiser. I am calling because it was noted that you returned to the hospital after you were discharged from (NAME OF SNF). It should not take more than 10 minutes. Would that be ok with you? Can you share with me what happened between the time you left (NAME OF SNF) and the time you returned to the hospital?

8. Why were you hospitalized and transferred to a Skilled Nursing Facility earlier this month? (prompt for patient / caregiver understanding of the reason for hospitalization and SNF admmission)

Enter your answer

9. How was your experience during the discharge preparation from the Skilled Nursing Facility?

Enter your answer

10. Before your discharge from (NAME OF SNF), did you receive information re: medications including where to pick up?

- [ ] Yes
- [ ] No
- [ ] Declined

11. Before your discharge from (NAME OF SNF), did you receive information recommended equipment?

- Yes
- No
- Declined

12. Before your discharge from (NAME OF SNF), did you or your caregiver receive training?

- Yes
- No
- Declined

13. Before your discharge from (NAME OF SNF), did you receive written discharge instructions?

- Yes
- No
- Declined

14. Who was helping you at home after your discharge from (NAME OF SNF)

Enter your answer

14. Who was helping you at home after your discharge from (NAME OF SNF)

Enter your answer

15. When did you start not feeling well? What did you do to manage your symptoms at home? Did you call anyone (PCP, Home Health, family, etc) before coming back to the hospital?

Enter your answer

16. In our efforts to provide the best possible care to you and others like you, can you think of anything that could have been done differently when you left (NAME OF SNF) so that you might not have needed to return to the hospital so soon?

Enter your answer

17. Themes Identified

- [ ] Disease Trajectory
- [ ] Inadequate Care / Lack of Caregiver
- [ ] Did not or difficulty understanding Discharge Instructions
- [ ] Medications Not Available
- [ ] Appropriate DME not available
- [ ] Inadequate / lack caregiver training
- [ ] Unable to reach PCP/ Home Health - including no contact info
- [ ] Inappropriate Discharge Disposition
- [ ] Non Compliance
- [ ] Other

18. Any other pertinent information?

Enter your answer

Appendix G. Project Charter

Testing a New Workflow to Integrate the Voice-of-the-Customer in Readmission Analysis for Skilled Nursing Facility (SNF) Readmissions from Home

Project Charter

Stephanie Bilbao

University of San Francisco

Project Charter: Testing a New Workflow to Integrate the Voice-of-the-Customer in Readmission Analysis for Skilled Nursing Facility (SNF) Readmissions from Home

Global Aim: To reduce SNF readmissions from home from 13% in 2020 to 10% in 2021.

Specific Aim: The aim of this project is to increase utilization of the Voice-of-the-Customer template in readmission analysis for all SNF readmissions from home from 0% to 90% by July 15, 2021.

Background: The organization's Northern California regional goal for SNF readmissions is 17% and observed/expected (O/E) of 0.72. From December 2019 to October 2020, the SNF department's performance was at 17% and 0.81 for a medical center in Fremont, California, and 19% and 0.84 for a medical center in San Leandro, California. Readmission reduction continues to be a focused goal and quality metric for the organization and the department in 2021. The data reflect that 13% of SNF patients were readmitted after they were discharged home from SNF. The nurse leader's role integrates evidence-based leadership practices that identify and assess outcomes, mitigate risk, enhance health promotion, deliver highly effective patient care, and ensure transparent relationships with stakeholders. Our patients are one of the major stakeholders in the healthcare system. One strategy to improve healthcare delivery is by engaging patients and their caregivers in the planning, delivery, and evaluation of healthcare services. A study

conducted by Khodyakov et al. (2019) reflected the importance of involving patients and caregivers in the process of developing clinical practice guidelines. The results of a study by Gehring et al. (2019) underscored the importance of assessing patients' perceptions and expectations, the need to actively engage patients in their own healthcare, and the importance of providing adequate support during the transition to home. Jacobsen et al. (2017) interviewed readmitted patients to gather information relevant to reducing readmissions. The findings from this study have potential implications for how SNF readmission data should be interpreted and how interventions to reduce readmissions should be designed in future studies. An opportunity identified in the microsystem assessment is the lack of patient/caregiver input, particularly on readmission analysis and interventions. The team collaborates with providers across venues of care; yet, we fail to incorporate the patient's voice and input. As an evidence-informed, quality improvement project, the team is looking to include the patient's and the caregiver's voice in the readmission analysis process.

Sponsors:

Chief of Continuum of Care – Skilled Nursing Facilities Dept	Dr. Sneha P. Patel
Continuing Care Service Director	Maribel Co

Goals: To standardize the implementation of a post-readmission survey using a new template to integrate the voice-of-the-customer in the analysis of SNF readmissions from home, which includes the following:

1. Identification of team comprised of physician and nurse champions.
2. Education and training for SNF RN case managers in experiential interviewing and using the new template for readmission analysis.
3. Validation of survey tool by reviewing with SNF physicians, nurse case managers, directors of nurses, SNF administrators, and SNF patients.
4. Conducting survey with SNF patients readmitted from home either by phone or face-to-face and entering date in a Microsoft Forms template.

5. Generate reports, including themes and opportunities identified, from Microsoft Forms.

Measures:

Measure	Data Source	Target
Outcome		
% documentation of post-readmission survey	Microsoft Forms	90%
Process		
% of patients/designated caregivers who participate in the survey	Microsoft Forms	70%
Balancing		
# of Member Services concerns related to care coordination of home discharge.	Emails from member services, department quality/ care concerns logs.	10% decrease from 2020

Team:

MD Co lead	Dr. Ragini Vykunta
RN Co Lead	Stephanie Bilbao
Quality Nurse Educator	Rica Enrile
SNF RN Coordinator Champions	Heddyliza Alegado Camille Ignacio Nona Mejia Cynthia Plantilla
IT Consultant	Randall Cooper

Measurement Strategy

Background (Global Aim): To reduce 30-dy SNF readmissions from home from 13% in 2020 to 10% in 2021.

Population Criteria: Skilled nursing facility patients rehospitalized from home.

Data Collection Method: Data will be obtained from the daily report from Business Strategy and Finance. This report shows inpatient and observation patients admitted to the hospital on the date listed who were either discharged or admitted from the facility selected within 30 days prior

to this admission. A retro-review of readmissions from home in 2020 and Q1 2021 will also be conducted to establish baseline. A Microsoft Forms template will be used to document the survey details of the Voice-of-the-Customer as part of the readmission analysis. The number of surveys completed will be compared against the Business Strategy and Finance Report to determine compliance. Other pertinent data will be generated from the Microsoft Forms platform.

Data Definitions:

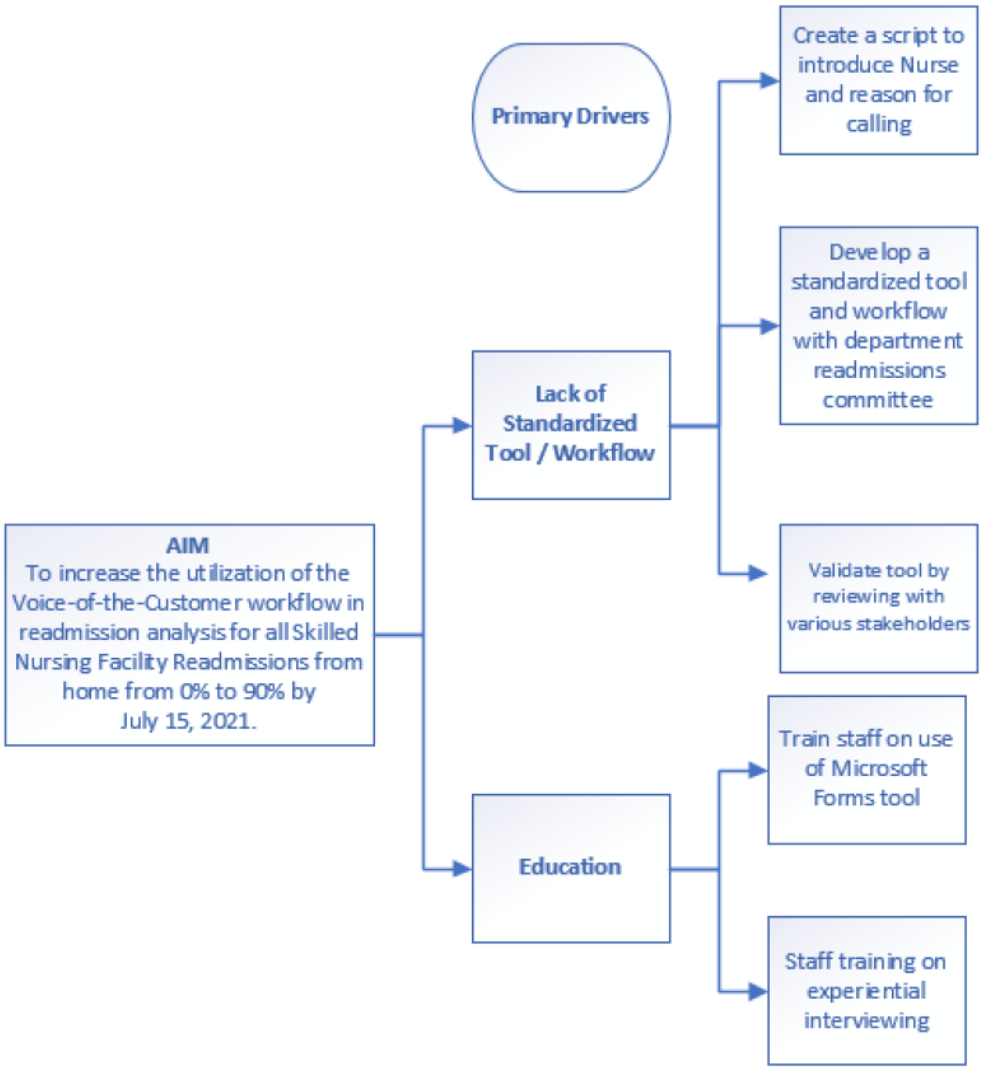
Data Element	Definition
Readmission	An admission to an acute care hospital within 30 days of discharge from the same or another acute care hospital.
SNF Readmissions from Home	# of patients rehospitalized after discharged from SNF within 30 days of the indexed hospital admission.
Member Services Concerns	Concerns reported by patients and their designated caregivers to Member Services related to care coordination of the patient's discharge from the SNF to home or community (assisted living or board and care facilities).
Patients, Designated Caregivers	Patients and/or their support systems, which could be family members, hired caregivers, or designated caregivers.

Measure Description:

Measure	Measure Definition	Data Collection Source	Goal
% documentation of post-readmission survey	N = # of post-readmission surveys conducted using Voice-of-the-Customer template	Microsoft Forms	90%
% of patients/ designated caregivers who participate in the survey	N = # of patients/ designated caregivers who participated in the readmission surveys conducted using Voice-of-the-Customer template	Microsoft Forms	70%

# of Member Services concerns related to care	N = # of concerns reported by patients and their designated caregivers to Member Services related to care coordination of the patient's discharge from the SNF to home or community (assisted living or board and care facilities)	Emails from Member Services, Department Quality /Care Concerns logs	No increase

Driver Diagram



GANNT Chart/Timeline

Testing a New Template to Integrate the Voice-of-the-Customer in Readmission Analysis for Skilled Nursing Facility (SNF) Readmissions from Home						
Timeline						
Tasks	Status	Owner	Start Date	Target Date	Actual End date	Comments
Pre-implementation Check List						
Create Strategic plan for project	Complete	SBilbao/ SNF Manager	2/1/2021	3/31/2021	4/30/2021	
• Establish population / inclusion criteria.	Complete	SBilbao/ SNF Manager	2/1/2021	2/7/2021	2/7/2021	
• Establish team	Complete	SBilbao/ SNF Manager	2/15/2021	2/28/2021	2/28/2021	
• Conduct literature review.	Complete	SBilbao/ SNF Manager	2/1/2021	3/5/2021	3/12/2021	
• Create draft template using Microsoft Forms	Complete	SBilbao/ SNF Manager	3/15/2021	3/31/2021	3/18/2021	
• Validate template by reviewing with different stakeholders: Physicians, Nurse Case Managers, Directors of Nurses, SNF Adminsitrators, Patients and Desginated Caregivers	Complete	SBilbao/ SNF Manager	3/18/2021	3/31/2021	3/31/2021	
Establish start date	Complete	Team	3/15/2021	3/31/2021	3/31/2021	proposed Go-live 5/3/2021.Acutal Go -live Date 4/5/2021
On-boarding/Education	Complete					
• Experiential intervewing training	Complete	Innovations consultant	3/15/2021	4/15/2021	4/15/2021	
• Staff training on use of template via Microsoft Forms platform	Complete	Educator/ Quality RN	3/15/2021	4/15/2021	4/8/2021	
• Training on how to generate data/ reports.	Complete	Educator/ Quality RN	3/15/2021	4/30/2021	4/30/2021	
Implementation						
• Conduct post DC survey using template	Complete	SBilbao/ SNF Manager, RN Champoins	5/3/2021	5/3/2021	4/5/2021	
• Weekly debriefs x 4 weeks	Complete	SBilbao/ SNF Manager	5/12/2021	6/2/2021	6/2/2021	
• Bi-Weekly debriefs x 4 weeks	Complete	SBilbao/ SNF Manager	6/9/2021	6/30/2021	6/30/2021	
• Monthly team meeting (every 2nd Thursday of the month x 3 monts	Ongoing	SBilbao/ SNF Manager	7/8/2021	9/10/2021	ongoing	
• Generate monthly report on themes and opportunities.	Ongoing	Educator/ Quality RN	6/4/2021	8/6/2021	ongoing	

Clinical Nurse Leader (CNL) Competencies

I. Outcomes Manager**:** The CNL "synthesizes data, information, and knowledge to evaluate and achieve optimal client outcomes" (King, 2019, p. 455). In this quality improvement project, the nurse leader integrates evidenced-based leadership practices that identify and assess outcomes, mitigate risks, and enhance delivery of effective patient care.

II. Client Advocate: A CNL ensures that patients and their support systems are well-informed and included in planning their care. They ensure transparent relationships with stakeholders. Patients are one of the major stakeholders in the healthcare system. This project's aim is to improve healthcare delivery by engaging patients and their caregivers in the analysis of their readmissions.

III. Systems Analyst and Risk Anticipator: The CNL "participates in systems review to improve quality of client care delivery" (King, 2019, p. 456). In this quality improvement, the global aim is to reduce readmissions of SNF patients. Themes or opportunities identified in this project will be used for focused readmission reduction interventions.

Appendix H. Statement of Non-Research Determination

CNL Project: Statement of Non-Research Determination Form

Student Name: Stephanie Edurese Bilbao

Title of Project: Testing a New Template to Integrate the Voice-of-the-Customer in Readmission Analysis for Skilled Nursing Facility (SNF) Readmissions from Home

Brief Description of Project:

A) Aim Statement: The aim of this project is to increase utilization of the Voice-of-the-Customer template in readmission analysis for all Skilled Nursing Facility Readmissions from home from 0% to 90% by the end of July 2021.

B) Description of Intervention: A Microsoft Forms template will be used to document the survey details of the Voice-of-the-Customer as part of the readmission analysis. The number of surveys completed will be compared against the Business Strategy and Finance Report to determine compliance. This report shows inpatient and observation patients admitted to the hospital on the date listed who were either discharged or admitted from the facility selected within 30 days prior to this admission.

C) How will this intervention change practice? An opportunity identified in the microsystem assessment is the lack of patient/caregiver input on readmission analysis and interventions. As an evidence-informed, quality improvement project, the team is looking to include the patient's and the caregiver's voice in the readmission analysis process by conducting a post-readmission survey using a template.

D) Outcome measurements: The Outcome Measure for this project is the documentation of post readmission surveys using the new template on Microsoft with a target of 90% of all SNF Readmissions from home.

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used; (http://answers.hhs.gov/ohrp/categories/1569)

This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

Comments:

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST *

Instructions: Answer YES or NO to each of the following statements:

Project Title:	**YES**	**NO**
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	**x**	
The specific aim is to improve performance on a specific service or program and **is a part of usual care**. ALL participants will receive standard of care.	**x**	
The project is **NOT** designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does **NOT** follow a protocol that overrides clinical decision-making.	**x**	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does **NOT** develop paradigms or untested methods or new untested standards.	**x**	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does **NOT** seek to test an intervention that is beyond current science and experience.	**x**	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	**x**	
The project has **NO** funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	**x**	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., **not** a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	**x**	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section; *"This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board."*	**x**	

ANSWER KEY: If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

STUDENT NAME (Please print): Stephanie Edurese Bilbao

_____

Signature of Student: Stephanie Edurese Bilbao

_____**DATE: 4/8/2021**

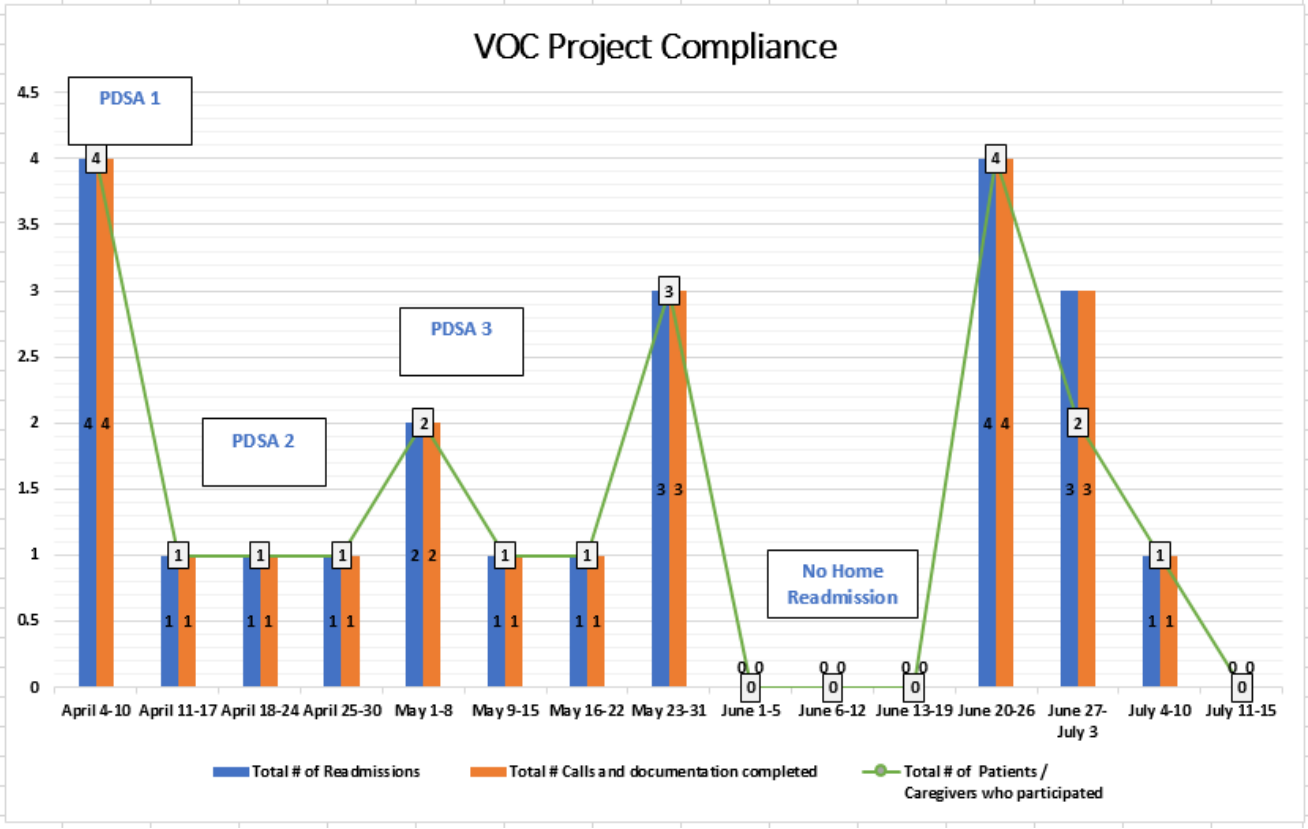
SUPERVISING FACULTY MEMBER NAME (Please print):
Professor David Ainsworth, MSN, RN, CNL

_____

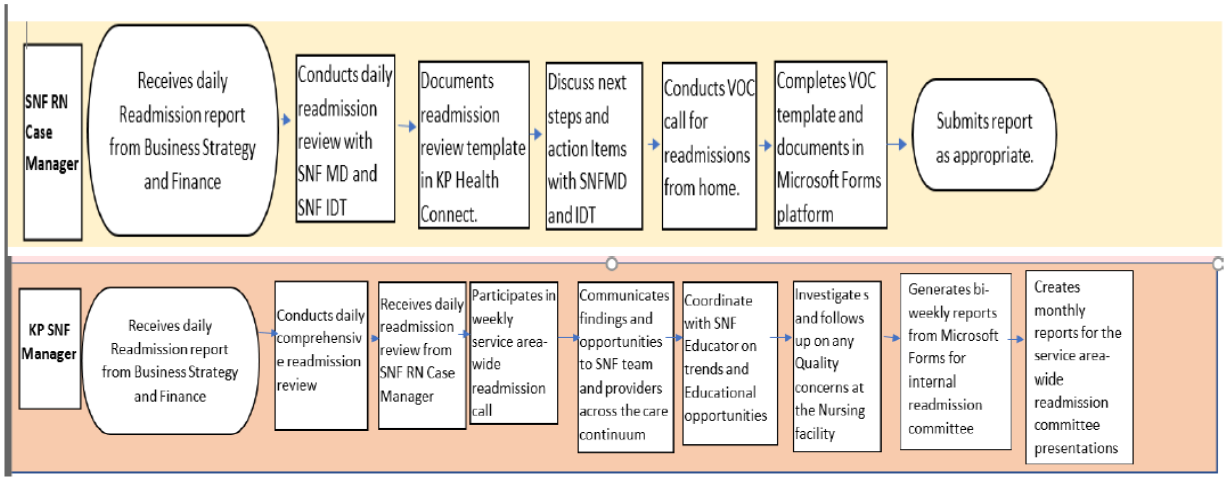
Signature of Supervising Faculty Member

_____**DATE 4/8/2021**

Appendix I. Run Chart



Appendix J. Process Maps



Appendix K. Learnings, Issues, and Next Steps

Appendix L. Microsystem Team Roles and Functions

Continuum Service Director

- Provides oversight and direction for continuum service lines (SNF, transitions, palliative care).
- Works to ensure members receive coordinated plans of treatment, customer-focused delivery of services, and quality, safe, cost-effective utilization of necessary services across the continuum.
- Provides education and support for KFH/TPMG staff on how to engage with internal and external continuum services and connect patients to appropriate resources.

Continuing Care SNF Manager

- Manages 24-hour departments providing patient care services.
- Ensures staff provide high-quality, accessible, cost-effective care and patient-focused services to members across the continuum, which comply with local, state, and federal requirements.
- Develops and maintains clinical standards of care and practice; responsible for all resource budgeting, selection and development.

Quality RN / Professional Development Consultant

- Provides program planning/management and consultative and strategic planning services to regional and local senior executives and nursing executives in order to assess/evaluate, maintain, improve, and develop professional nursing education, development, and practices; and to align the same with strategic organizational goals/objectives.
- Provides educational support for research utilization activities and development of strategies to evaluate/implement and manage best practice models that improve nursing and organizational performance.

Continuing Care Utilization Review RN Coordinator

- Conducts utilization and clinical reviews based on established treatment criteria for in-house patients and/or members who have been admitted to contracted facilities. Reviews utilization patterns, identifies trends and problems areas for special studies.
- Collaborates with physicians on clinical reviews, keeps them appraised of Kaiser clinical criteria.
- Assists other health care providers in the discharge planning process and triaging on alternative unit of care.
- Conducts goals of care conversations with patients and their designated decision makers.
- Counsels on Medicare and healthcare plan coverage.

SNF Program Continuity of Care Outcomes Coordinator

- Develop and manage utilization and outcome measurement systems for rehabilitation, using benchmarking tools.
- Produce and analyze outcome reports to enable Kaiser's contracted SNF's & Kaiser clinical & case management team to achieve "best practice" status in their rehabilitation programs.
- Interprets rehabilitation evaluation findings, evaluates treatment goals/plans, assesses clinical signs/symptoms to determine effectiveness of treatment and progress toward goals and gives input accordingly.
- Direct team to appropriate transition of members from one level of care to the next based on rehabilitative analysis and FIM outcomes.

High Mobility Occupational Therapist

- Specializes in assisting members to obtain the equipment (walkers and wheelchairs – manual and power) that will meet their medical mobility needs.
- Review benefits, equipment history, and assess home environments for obtaining the best fit for safe function.

SNF Advice RN

- Support Kaiser SNF physicians and licensed nurses in skilled and custodial nursing facilities by performing assessment/data collection in an ongoing systematic manner, focusing on physiologic, psychosocial, cultural, spiritual, and cognitive status; also including nutrition, pain, patient/family education, family involvement, and patient advocacy. Acts as liaison between KP SNF physicians and nursing home staff.

Administrative Specialist

- Organizes and expedites flow of work for the department manager's office and the department in accordance to the manager's method of operation. Schedules appointments and makes arrangements for meetings.
- Prepares special reports that require gathering, comparing, and summarizing data. Organizes and maintains files, correspondence, and records. Handles and frequently accesses highly confidential and sensitive information. Initiates any follow-up action items.
- Organizes and prepares routine correspondence for the department manager, as well as complex documents of multiple office technology and software applications. May act as the department's office resource for word processing and spreadsheet application.